Community Offender Substance Abuse Treatment Services
RFP #DOC-06-CST-RG

General Questions-

1. **Is there an expectation for the provider to solicit participants or will the DOC maintain the responsibility for referrals?**

A: DOC will provide all referrals.

2. **What is the time frame for a decision? How soon after will the grantee be expected to accept the first clients?**

A: Contract negotiations with selected proposers will begin in mid-May. Contractors are expected to begin services on July 1 2005.

3. **Is this a re-bid of existing contracts?**

A: This is a re-bid of a current contract.

4. **Can we get a list of the applicant organizations submitting Letters of Intent To Bid on this RFP?**

A: A list is attached.

5. **In addition to ASI, which is referenced in the RFP, what evaluation tools are endorsed by DOC?**

A: The DOC uses the ASI and TCUDSII, other tools can be proposed, further discussion can occur during contract negotiations.

6. **The RFP indicates that for the New Haven area the level of demand will probably be 250 active clients per year: 200 in Treatment, 50 in Aftercare, and 65 projected admissions monthly. Does this mean approximately 250 clients in treatment at any time or over the course of the year?**

A: This indicates the active caseload at any time.

Budget Questions-

7. **May an applicant include transportation supports (i.e. bus passes) in the program budget if they are used to increase offender engagement in treatment and support compliance with the program?**

A: Those costs are acceptable if appropriate to the program proposed.

8. **What dollars are available for the start-up costs, including things like security systems, furniture, etc.?**

A: Specific start up dollars have not been identified. Proposal should indicate what start up funds are being requested and what those funds will be used for.

9. **Will these services be funded by a flat contract regardless of how many of the slots are being utilized, or will funding be dependent upon the number of referrals from the DOC and the actual utilization?**

A: Contracts resulting from this RFP will be funded based on approved capacity. DOC reserves the right to adjust that funding level if, after an appropriate period, it becomes obvious that the need or utilization for that level of funding does not exist.

10. Start up costs will include the purchase of various security safeguards. Is there an expectation that such systems would be bondable?

A: The DOC is not anticipating seeking any bond funds for proposed/funded programs.

11. How will the flow of funding occur during the phase-in of the program?

A: That will be a contract negotiation item.

12. What part of the funding is new or a re-allocation of funds?

A: All funds are re-allocation.

13. How much funding is available?

A: A specific level of funding has not been determined.

14. Can we get a breakdown on the value per technical requirements? (page 5)

A: This breakdown will be developed by the Screening Committee. It is fair to say that all items in this section are of relatively equal value.

15. Is it correct that the budget section should include both an 11-month budget for FY2006 and an annualized, 12 month, budget that would apply in FY2007?

A: No. That page is an example, allowing for a program to begin on August 1, 2005. It is preferred that programs begin on July 1, 2005.

16. What is the estimated cost per person per slot?

A: The DOC does not establish that. It is through submitted proposals that that figure is derived.

17. Will the DOC consider proposals that include Phase In Costs, and if so, how long a Phase In period would be permitted?

A: DOC will consider proposals with a phase in period. Full implementation after July 1, 2005 will reduce ranking against programs that will begin on that date.

18. Can we bill clients on a sliding scale?

A: You may propose that. However, you cannot propose not providing services to offenders unable to pay.

Service Questions-

19. The geographic area of Willimantic/Danielson is not listed; does this mean you are not accepting proposals for this area?

A: The DOC Norwich/New London Area includes Willimantic/Danielson, so proposals for that area are acceptable.

20. Are these services new or additional or is there currently a contracted provider? If existing, who is the incumbent provider?

A: The current provider is the University of Connecticut Health Center/Correctional Managed Health Care.

21. Will the collaborative DMHAS/DOC/CSSD transitional case management program provide services to offenders on transitional supervision and parole who are receiving substance abuse treatment services under this request for proposals? If not, is case management a desired component of the requested services?

A: Proposals should, where appropriate to the program, provide for case management. The collaborative transitional case management program should not be considered, though it may eventually be incorporated.

22. On page three of the RFP, it states that aftercare should be available. Can you define specifically what DOC means by aftercare? Does this include participation in peer-based recovery supports? Should aftercare services be included in the total proposal cost? What level of reporting to DOC is required for clients participating in aftercare services? How long should the aftercare be available? Is urinalysis expected to continue once a client has reached aftercare?

A: Aftercare is recovery support following a period of primary treatment. The proposal should include a model, which can include peer-based recovery supports, and be included in the total program. Reporting of participants will be expected and a proposal should include those details. Random urinalysis would be expected.

23. Is there any data available from existing reporting and performance measures on the number of offenders completing treatment, dropping out, etc.?

A: That information is not currently available.

24. Are programs expected to serve both women and men concurrently, or are gender specific services sought?

A: Gender specific services will be expected.

25. Are medication management services for offenders with psychiatric involvement available through other contractors in the community or should these services be included under the proposed services?

A: They should be included in the cost of services being proposed, either as a direct service or utilizing community resources. If you plan on utilizing community resources, identify them and indicate that you have reason to anticipate a cooperative relationship.

26. Regarding urines, will DOC accept on-site self-admission for positive tests or is a lab test also required?

A: On-site self-admission of positive urinalysis will be accepted.

27. Does UCONN and LMG currently provide services in the 4 areas mentioned in the RFP?

A: Services in these areas are currently provided by UCONN.

28. What type of beds – male or female – would fill a need that DOC has? Is there a need for a 15-bed female facility?

A: DOC is not seeking a residential program.

29. Is there a preferred model for evidence-based services?

A. Preferred models are MI/MET, CBT and Strength-based, other models will be reviewed.

30. On page 2, Services to be Provided #2, it states that "Evaluations and program delivery shall be provided by CADAC certified personnel. However, on page 4, Staffing, it states that "licensed or certified substance abuse counselors preferred." Which of these statements is accurate?

A. CADC or LADC should be providing services. The statement on page 2 was in error.

31. The length of treatment is targeted at approximately 3 months. Is the DOC willing to allow for individuals who require a greater length of time for treatment?

A. Yes

32. Are the 4 tiers expected to be incorporated in the program design, and, if so, how can I access them?

A. The community programming should be consistent with the Tier program an offender may have participated in while incarcerated. See attached Tier program structure.

33. What kind of design changes would you be particularly interested in?

A. The Department is not "interested" in any particular design change. Proposals should clearly describe the program design being offered.

34. Will you pay for an outpatient psychiatrist and outpatient mental health services?

A. No

35. Is there flexibility in the length of the model, i.e. 4 months vs. 3 months?

A. Yes, based upon offender need.

36. What is the Addiction Services Program Discharge Summary?

A. See form attached.

37. Would you consider other Master's level professionals for evaluation and program delivery?

A. They should be substance abuse treatment professionals.

38. Is weekly urinalysis required just during treatment or is it also required in aftercare? Do you have a particular method of testing that is preferred?

A. Weekly during treatment, random during aftercare.

Letters of Intent Recieved

Alcohol & Drug Recovery Centers, Inc.
500 Blue Hills Ave.
Hartford CT, 06112

Catholic Charities, Inc.
839-841 Asylum Ave.
Hartford, CT 06105-2801

CNV Help
900 Watertown Ave.
Waterbury, CT 06708

Chemical Abuse Services Agency, Inc.
PO Box 2197
Bridgeport, CT 06608

Community Renewal Team, Inc.
555 Windsor St.
Hartford, CT 06120-2418

Connecticut Renaissance
9 Mott Ave., Ste 302
Norwalk, CT 06850

The Connection, Inc.
955 South Main St.
Middletown, CT 06457

CSI, Connecticut
4 Griffin Rd., North
Windsor, CT 06095

FHM Services, Inc.
466 Long Hill Rd.
Groton, CT 06340-4107

Forensic Health Services
205 Orange Street, 3rd Floor
New Haven, CT 06514

Hill Health Corporation
400 Columbus Ave
New Haven, CT 06519

Liberty Community Services
254 College St., 2nd Floor
New Haven, CT 06510

McCall Foundation
58 High St.
Torrington, CT 06790

NEON
98 S. Main St.
Norwalk, CT 06854

Perception Programs
1003 Main St.
Willimantic, CT 06226

Wheeler Clinic
91 Northwest Dr.
Plainville, CT 06062

ADDICTION SERVICES UNIT - PROGRAM DISCHARGE SUMMARY

Inmate Name_____ Inmate Number _____

Prior Addiction Services Programming During This Incarceration

	Tier	Completed (Y/N)	Date Discharged

Current Addiction Services Programming

Facility_____ Tier _____ Admission Date _____Discharge Date _____

Components:

Program Components	Treatment Hours	Completed (Y/N)	Completion Date
1.			
2.			
3.			
4.			
5.			

Progress on treatment plan goals: (list each goal identified in the Treatment Plan and provide a brief summary of the progress achieved)

Treatment Plan Goal	Progress Noted
1.	
2.	
3.	
4.	
5.	

Reason for discharge: (Circle Appropriate Number) **1.** Completed treatment **2.** Non-compliance behavioral **3.** Non-compliance substance abuse **4.** Non-DR related transfer **5.** Voluntarily left the program **6.** Released prior to completion **7.** Other: _____

Summary: Course of treatment: (assessment upon entering treatment, problems/breakthroughs experienced during treatment, and assessment at time of discharge)

_____

_____

_____

_____

_____

_____

Recommendations:

_____

_____

Referral upon discharge:

_____

_____

Counselor Signature _____ _____**Date** _____

Clinical Supervisor Signature _____**Date** _____

5/1/00

CONNECTICUT DEPARTMENT OF CORRECTION
Addiction Services Unit – Tier Program Structure

The Connecticut Department of Correction's (DOC) Objective Classification System indicates that 88% of inmates have a substance abuse history and a significant need for treatment. The DOC Addiction Services Unit operates programs in 18 correctional facilities, and focuses on level of intervention, point of impact, and continuity of care.

Definitions:

1. Level of Intervention: The amount and intensity of treatment required for an individual to begin recovery from substance abuse. Research indicates that longer and more intensive treatment results in more successful recovery.

2. Point of Impact: The point of incarceration at which intervention and treatment are most effective. The curriculum is designed based upon various points of impact. Substance abuse education is offered upon admission to the correctional system at the initial point of impact to break down denial. Recovery/Criminality Issues, 12 Steps and Skill Development are offered at the midpoint. Relapse Prevention and Family Education are offered toward the end of the sentence prior to release to the community.

3. Continuity of Care: Substance abuse treatment is available throughout the correctional system. An inmate can continue their treatment as they move from one facility to another.

Addiction Services operates on the premise that recovery is a developmental process in which a client learns new skills, values and ways of thinking. The recovery process includes three phases and requires specific issues, tasks and skills to be mastered at each phase. In the transition phase, tasks such as breaking down denial, connecting life's problems with substance abuse and confronting the consequences of substance abuse need to be accomplished. The tasks of early recovery include identifying self-defeating patterns of behavior, learning coping and stress management skills, and developing identification with recovery. In the later phase of recovery, a client learns to alter self-defeating behavior, acknowledge interpersonal responsibilities, and develop a balanced drug-free lifestyle.

Each facility conducts specific Tier programs in accordance with written standards and program models are designed to meet the needs of specialized populations, i.e., male, female, youth, long term, etc.

Tier 1 and Tier 2 are primarily "motivational" programs.

Tier 1 - Basic Substance Abuse Education

Tier 1 is the lowest level of intervention, a one to two week cycle. It consists of six (6) substance abuse education group sessions, including a minimum of one fellowship meeting. Tier 1 certificates are presented upon completion of the six- (6) sessions. The optimal inmate to counselor ratio is 25:1. Tier 1 graduates who are positive role models may be utilized as Inmate Peer Mentors. Tier 1 serves as an entry point intervention at presentence and admitting facilities to encourage as many inmates as possible to seek further treatment involvement. In addition, a Community Resources Day is held quarterly. This program provides a linkage with community resource agencies located in their respective communities for inmates who are within ninety days of release.

Tier 2 - Intensive Outpatient

Tier 2 is the next level of intervention, a 10-week cycle. Curriculum program components are provided three times a week in a non-residential setting. This Tier requires participants to attend fellowship meetings. Tier 2 certificates are presented upon completion of the required number of sessions in each program component. The program components include Substance Abuse Education, 12 Step Format focusing on Steps 1,2,3 and Skill Development. The optimal inmate to counselor ratio is 20:1. Tier 2 graduates who are positive role models may be utilized as Inmate Peer Mentors. TIER 2 serves to lay a

foundation of basic information, promote a personal identification with recovery, and motivate inmates to seek further treatment involvement.

Tier 3 and Tier 4 are long term "change" programs.

Tier 3 – Daycare

Tier 3 is a higher level of intervention where long term "positive change" is the expected outcome. This is a 16-week program held in a non-residential setting. Curriculum components consisting of Relapse Prevention and Recovery Skills, 12 Step Format focusing on Steps 4 & 5, Skill Development and an elective group are held four times per week. Curriculum enhancements such as journals and homework can be utilized to compliment group sessions. The optimal inmate to counselor ratio is 20:1. Tier 3 participants are expected to attend school or hold a job when not attending the program components. Tier 3 certificates are presented upon successful completion of the required number of sessions in each program.

Tier 4 - Residential Treatment

Tier 4 is the highest level of intervention. Outcome research has demonstrated positive long-term outcomes for this level of intervention. This 6-month program is conducted in a residential modified therapeutic community setting with full time programming. Programs are located in a housing unit separate from general population inmates. Within this milieu, inmates are encouraged to practice and learn the material presented in the curriculum. The program components and community atmosphere stimulate the development of personal responsibility and discipline. Inmates take an active role in the treatment community through assignments to jobs and program committees. Tier 4 participants are expected to attend school or hold a job while in the program. Inmates in the Tier 4 programs move through phases as they demonstrate improvement in their behavior and attitude. The optimal inmate to counselor ratio is 10:1. Tier 4 certificates are presented to inmates who have successfully completed the required phases. Tier 4 graduates who are positive role models may be utilized as Inmate Peer Mentors.